Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Alliance Medical Group

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4- 14-3174-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All documentation has been provided for accurate review. Services have been provided to the patient to further help resume her duties for employment, we feel we have taken the necessary steps to help her through the process."

Amount in Dispute: $ 904.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills are denied correctly as required OB qualifier was not listed in 24I."

Response Submitted by: Gallagher Bassett Services Inc., 6404 International Parkway, Ste 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2012 November 5, 2012 December 10, 2012 January 28, 2013 October 28, 2013	99204, L3908, 99080 99213, 99080 99213, 99080 99213, 99080 99213, 99080	$904.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.10 sets out requirements related to billing forms and formats.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 16 – Claim lacks information or has submission/billing errors which is needed for adjudication

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. Was the claim submitted in compliance of Division rules?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is October 8, 2012, November 5, 2012, December 10, 2012 and January 28, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 17, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of services.

2. The carrier denied the disputed services as 16 – "Claim lacks information or has submission/billing errors which is needed for adjudication." 28 Texas Administrative Code §133.10 states in pertinent part, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');." Review of the submitted medical claim finds section 17 and 17a are not filled in. The carrier's denial is supported as requirements of Division rules in submission of medical claims are not met. No payment can be recommended.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		October , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.